Department of Medical Assistance Services
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http://www.dmas.state.va.us

MEDICAID MEMO

TO: All Providers and Managed Care Organizations (MCO) Participating in the Virginia Medical Assistance Program

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 05/19/2016

SUBJECT: Managed Long Term Services and Supports (MLTSS) Initiative

BACKGROUND

The Department of Medical Assistance Services (DMAS), with support from the Governor and the General Assembly, is working to implement a new managed long term services and supports (MLTSS) initiative. MLTSS is set to launch July 1, 2017 and will operate statewide across six regions as a mandatory Medicaid managed care program. MLTSS focuses on improving access, quality, and efficiency through a coordinated delivery system that emphasizes integrated care and value-based, alternative payment models. MLTSS will serve approximately 212,000 individuals, including children and adults with disabilities and complex needs. MLTSS will also include individuals who qualify for both Medicare and Medicaid (known as dual eligible) and individuals that receive long term services and supports through nursing facilities or through DMAS home and community based services (HCBS) waivers (except the Alzheimer's Assisted Living waiver). However, at this time, individuals enrolled in the three HCBS waivers that specifically serve individuals with intellectual and developmental disabilities (ID/D) will be enrolled in MLTSS for their non-waiver services only (i.e., medical, behavioral health, pharmacy, and transportation services); the individual's *ID/D waiver services* will continue to be covered through fee-for-service. Additionally, individuals in the Alzheimer's Assisted Living Waiver and the Program of All-inclusive Care for the Elderly (PACE) will be excluded from MLTSS participation. Full details regarding included and excluded MLTSS populations and services carved-out of the MLTSS health plan contract are provided in the table on page 2.

MLTSS CONTRACTING

DMAS will select MLTSS managed care plans through a request for proposals (RFP) competitive procurement process. The RFP requires interested health plans to include their preliminary network, including signed contracts or letters of intent (LOIs) specifically for the MLTSS program as part of their proposal. While providers are not required to contract or sign letters of intent with interested plans, this part of the process offers providers an opportunity through LOIs to demonstrate their preference. For community mental health, substance abuse treatment, and LTSS service providers the LOI should include the services offered by the provider. *A listing of these services is available in the MLTSS Provider Network Adequacy Data submission manual, on pages 46-48, available at: http://www.dmas.virginia.gov/Content_atchs/mltss/Provider%20Network%20Reporting%20Requirements.pdf.* DMAS anticipates that it will enter into contracts with no fewer than two (2) MLTSS health plans per region. ***Final networks will require signed contracts.*** The health plans' contracting process requires that

providers credential into their networks; ***the credentialing process may take 90-120 days or more to compete.***

ADDITIONAL INFORMATION

Additional information about MLTSS and a copy of the MLTSS RFP are available on the DMAS website: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

MLTSS Included Populations:

1. Dual eligible individuals with full Medicaid and any Medicare coverage (Medicare A and/or B).
   i. Individuals who have opted-out of the CCC program will transition to the MLTSS Program beginning in July 2017.
   ii. Individuals enrolled in the CCC program will transition to MLTSS Program in January 2018, which is after the CCC program ends.
2. Non-dual eligible individuals (including the Health and Acute Care Program (HAP) population enrolled in DMAS' Medallion 3.0 program) who receive long term services and supports (LTSS), either through an institution or through five (5) of DMAS' home and community-based services (HCBS) waivers:
   i. Day Support for Persons with Intellectual Disabilities (DS)*
   ii. Elderly or Disabled with Consumer-Direction (EDCD)
   iii. Individual and Family Developmental Disabilities Support (DD)*
   iv. Intellectual Disabilities (ID)*
   v. Technology Assisted (Tech)
3. Remaining aged, blind, and disabled (ABD) individuals (not dually eligible for Medicare and Medicaid and not receiving LTSS). *The majority of these ABD individuals will transition from DMAS' Medallion 3.0 program to MLTSS on January 1, 2018.*

**ID/DD/DS waiver services will not be included in MLTSS at this time; for these individuals the managed care plan will provide coverage for the non-waiver services (see carved-out services below).*

MLTSS Excluded Populations:

Excluded Populations are not MLTSS eligible; coverage will continue through fee-for-service (except PACE and Medallion 3.0). Some of the excluded populations may be transitioned to MLTSS at a later time.

1. Limited Coverage Groups (Family Planning, GAP, QMB only, etc.)
2. ICF-ID Facilities
3. Veterans Nursing Facilities
4. Psychiatric Residential Treatment Level C
5. Alzheimer's Assisted Living Waiver
6. Money Follows the Person (MFP)
7. Hospice (MLTSS enrolled individuals who elect hospice will remain MLTSS enrolled)
8. PACE – coverage continues through the PACE provider.
9. Medallion 3.0 and FAMIS managed care enrolled individuals; coverage continues through the MCO

MLTSS Carved-Out Services:

Carved-out services are paid through fee-for-service for MLTSS enrolled individuals. Some of these services may be included in MLTSS at a later time

1. ID, DD, and DS Waiver Services, including waiver related transportation services, until after the completion of the ID/DD redesign
2. Dental
3. School Health Services
4. Community Intellectual Disability Case Management
5. Individuals and Families Developmental Disability Services Support Coordination.
6. Preadmission Screening

COMMONWEALTH COORDINATED CARE

Commonwealth Coordinated Care (CCC) is a managed care program that is coordinating care for thousands of Virginians who have both Medicare and Medicaid and meet certain eligibility requirements. Please visit the website at http://www.dmas.virginia.gov/Content_pgs/altc-home.aspx to learn more.

MANAGED CARE PROGRAMS

Many Medicaid individuals are enrolled in one of the Department's managed care programs (Medallion 3.0, CCC and PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC): http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Program of All-Inclusive Care for the Elderly (PACE): http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA.pdf

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.